DSS
Strong Families - South Dakota's Foundation and Our Future

Department of Social Services
Division of Behavioral Health
3900 W. Technology Circle, Suite 1
Sioux Falls, SD 57106

Plan of Correction

Program Name: Dakota Counseling Institute	**Date Submitted:** 5/13/2019	**Date Due:** 06/14/2019

Administrative POC-1	
Rule #: 67:61:02:21 and 67:62:02:19	**Rule Statement:** **Sentinel event notification.** Each accredited agency shall make a report to the division within 24 hours of any sentinel event including; death not primarily related to the natural course of the client's illness or underlying condition, permanent harm, or severe temporary harm, and intervention required to sustain life. Each agency shall develop root cause analysis policies and procedures to utilize in response to sentinel events. Each agency shall also report to the division as soon as possible: any fire with structural damage or where injury or death occurs, any partial or complete evacuation of the facility resulting from natural disaster, or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours. The agency shall submit a follow-up report to the division within 72 hours of any sentinel event and the report shall include: 1) A written description of the event; 2) The client's name and date of birth; and 3) Immediate actions taken by the agency.
Area of Noncompliance: The agency has an incident report form, but the division contact information needs to be added.	
Corrective Action (policy/procedure, training, environmental changes, etc): Incident or Accident Reporting Procedures were updated. A Sentinel Policy was implemented.	**Anticipated Date Achieved/Implemented:** **Date** May 6, 2019
Supporting Evidence: Attachment A POC-1.	**Person Responsible:** Executive Director
How Maintained: The Executive Director is notified of all client incidents and/or facility concerns. In the event it classifies as a sentinel or major facility event, the Director will ensure the procedure is followed.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-2	
Rule #: 67:61:05:01	**Rule Statement:** **Tuberculin screening requirements.** Tuberculin screening requirements for employees are as follows: 1) Each new staff member, intern, and volunteer shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12 month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last

	skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not required if documentation is provided of a previous position reaction to either test; 2) A new staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease; 3) Each staff member, intern and volunteer with a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of *Myobacterium* tuberculosis. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and 4) Any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.

Area of Noncompliance: The personal files reviewed were not in compliance with TB testing.

Corrective Action (policy/procedure, training, environmental changes, etc): The Tuberculin Testing Procedures were updated to reflect a two-step done in the first month of employment versus upon hire and then annually. This should avoid the lack of follow through in a year.	**Anticipated Date Achieved/Implemented:** **Date** June 10, 2019
Supporting Evidence: Attachment A POC-2.	**Person Responsible:** Supervisor/Nurse
How Maintained: The nurse will keep a binder of new staff with their initial and then follow up test to track. This will give staff up to eleven months to coordinate if their shift or location is not convenient with the nursing hours. Without tracking ALL staff, the numbers will be more manageable.	**Board Notified:** Y ☐ N ☒ n/a ☐

Administrative POC-3	
Rule #: 67:61:08:02 [4]	**Rule Statement:** **Control, accountability, and storage of medications and drugs.** Each residential program shall meet the following requirements for the control, accountability, and safe storage of medications and drugs: 4) All controlled drugs shall be stored in a separate locked box or drawer in the medication storage area;

Area of Noncompliance: The controlled medications need to be double locked in a separate locked box or drawer in the medication storage area.

Corrective Action (policy/procedure, training, environmental changes, etc): A separate lock box was placed in the locked medication cabinet for the controlled meds.	**Anticipated Date Achieved/Implemented:** **Date** April 30, 2019
Supporting Evidence: Staff were trained on this procedure April 30 during clinical staffing. The updated policy is attached as A POC-3, 4.	**Person Responsible:** Residential Supervisor
How Maintained: All staff are to ensure this box is locked as well as the med cabinet unless meds are being distributed. Daily checks are documented.	**Board Notified:** Y ☐ N ☒ n/a ☐

Administrative POC-4	
Rule #: 67:61:08:04	**Rule Statement:** **Records of receipt, administration, and disposition of scheduled drugs.** Each residential program shall maintain a separate log book to record the receipt and disposition of all Schedule II drugs. A residential program shall maintain a record of the receipt and administration of Schedule II, III, and IV drugs in a client's case records.
Area of Noncompliance: The agency did not maintain a separate log book to record the receipt and disposition of all schedule II, III, IV drugs.	
Corrective Action (policy/procedure, training, environmental changes, etc): A separate log book is kept for the receipt and disposition of Schedule II, III, IV drugs.	**Anticipated Date Achieved/Implemented:** **Date** April 30, 2019
Supporting Evidence: Staff were trained on this procedure April 30 during clinical staffing. The updated policy is attached as A POC-3, 4.	**Person Responsible:** Residential Supervisor
How Maintained: Overnight staff review the mars and will ensure that the separate log book is utilized when appropriate.	**Board Notified:** Y ☐ N ☒ n/a ☐

Client Chart POC-1	
Rule #: ARSD 67:61:07:05 and 67:62:08:05	**Rule Statement:** **Integrated assessment.** An addiction counselor or counselor trainee shall meet with the client and the client's family if appropriate, to complete an integrated assessment, within 30 days of intake. The integrated assessment includes both functional and diagnostic components. The assessment shall establish the historical development and dysfunctional nature of the client's alcohol and drug abuse or dependence and shall assess the client's treatment needs. The assessment shall be recorded in the client's case record and includes the following components: 1) Strengths of the client and the client's family if appropriate, as well as previous periods of success and the strengths that contributed to that success. Identification of potential resources within the family, if applicable; 2) Presenting problems or issues that indicate a need for services; 3) Identification of readiness for change for problem areas, including motivation and supports for making such changes;

	4) Current substance use and relevant treatment history, including attention to previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization; 5) Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history; 6) Family and relationship issues along with social needs; 7) Educational history and needs; 8) Legal issues; 9) Living environment or housing; 10) Safety needs and risks with regards to physical acting out, health conditions, acute intoxication, or risk of withdrawal; 11) Past or current indications of trauma, domestic violence, or both if applicable; 12) Vocational and financial history and needs; 13) Behavioral observations or mental status, for example, a description of whether affect and mood are congruent or whether any hallucinations or delusions are present; 14) Formulation of a diagnosis, including documentation of co-occurring medical, developmental disability, mental health, substance use disorder, or gambling issues or a combination of these based on integrated screening; 15) Eligibility determination, including level of care determination for substance use services, or SMI or SED for mental health services, or both if applicable; 16) Clinician's signature, credentials, and date; and 17) Clinical supervisor's signature, credentials, and date verifying review of the assessment and agreement with the initial diagnosis or formulation of the initial diagnosis in cases where the staff does not have the education or training to make a diagnosis. Any information related to the integrated assessment shall be verified through collateral contact, if possible, and recorded in the client's case record.

Area of Noncompliance: Many of the client's assessments in the SUD and MH charts were missing one or more of the required. The integrated assessments need to be completed within 30 days of first appointment.

Corrective Action (policy/procedure, training, environmental changes, etc): Staff training was held with all Clinical Staff who prepare these assessments.	**Anticipated Date Achieved/Implemented:** **Date** 6/11/19
Supporting Evidence: Staff were trained during the clinical staff meeting. The handout is enclosed as Attachment CC POC-1.	**Person Responsible:** Clinical Director
How Maintained: All new clinical staff will be educated on all facets of the State Contract and its attachments, including training on the Integrated Assessments.	**Board Notified:** Y ☐ N ☒ n/a ☐

Client Chart POC-2	
Rule #: 67:62:08:07	**Rule Statement:** Mental Health Clients; The initial treatment plan shall be completed within 30 days of intake

	and shall include the mental health staff's signature, credentials, and date of signature, and the clinical supervisor's signature and credentials if the mental health staff does not meet the criteria of a clinical supervisor as defined in subdivision 67:62:01:01(8). Evidence of the client's or the client's parent or guardian's participation and meaningful involvement in formulating the plan shall be documented in the file. This may include their signature on the plan or other methods of documentation. The treatment plan shall: 1) Contain either goals or objectives, or both, that are individualized, clear, specific, and measurable in the sense that both the client and the mental health staff can tell when progress has been made; 2) Include treatment for multiple needs, if applicable, such as co-occurring disorders that are relevant to the client's mental health treatment; 3) Include interventions that match the client's readiness for change for identified issues; and 4) Be understandable by the client and the client's family if applicable. A copy of the treatment plan shall be provided to the client, and to the client's parent or guardian if applicable.

Area of Noncompliance: One or more of elements were missing from MH treatment plans. Ensure each plan is individualized to the client.

Corrective Action (policy/procedure, training, environmental changes, etc): Staff training with all Clinical Staff who prepare treatment plans with their clients.	**Anticipated Date Achieved/Implemented:** **Date** 6/11/19
Supporting Evidence: Staff were trained during the clinical staff meeting. The handout is enclosed as Attachment CC POC-2.	**Person Responsible:** Clinical Supervisor
How Maintained: All new clinical staff will be educated on all facets of the State Contract and its attachments, including training on the Initial Treatment Plans.	**Board Notified:** Y ☐ N ☒ n/a ☐

Client Chart POC-3	
Rule #: 67:62:08:08	**Rule Statement:** **Treatment plan review -- Six month review.** Treatment plans shall be reviewed in at least six month intervals and updated if needed. Treatment plan reviews shall include a written review of any progress made toward treatment goals or objectives, significant changes to the treatment goals or objectives, and a justification for the continued need for mental health services. Treatment plan reviews may be documented in the progress notes or other clinical documentation; however, any changes in the client's treatment plan goals or objectives shall be documented in the treatment plan. Treatment plan reviews shall include the mental health staff's signature, credentials, and date.

Area of Noncompliance: In review of the MH treatment plan reviews, one or more elements were missing from the treatment plan reviews.

Corrective Action (policy/procedure, training, environmental changes, etc): Staff training with all Clinical staff who prepare treatment plan reviews – six month reviews with their clients.	**Anticipated Date Achieved/Implemented:** **Date** 6/18/19
Supporting Evidence: Staff training will be held during the clinical staff meeting on June 18. The handout is enclosed as Attachment CC POC-3.	**Person Responsible:** Clinical Director
How Maintained: All new clinical staff will be educated on all facets of the State Contract and its attachments, including training on Treatment Plan Reviews-Six Month Review.	**Board Notified:** Y ☐ N ☒ n/a ☐

Client Chart POC-4	
Rule #: 67:62:08:09	**Rule Statement:** **Supervisory reviews.** Staff meeting clinical supervisory criteria as defined in subdivision 67:62:01:01(8), shall conduct one treatment plan review at least annually. This review shall include documentation of: 1) Progress made toward treatment goals or objectives; 2) Significant changes to the treatment goals or objectives; 3) Justification for the continued need for mental health services; and 4) Assessment of the need for additional services or changes in services, if applicable. This review qualifies as a six month review pursuant to § 67:62:08:08. The annual supervisory review shall include the clinical supervisor's signature, credentials, and date.
Area of Noncompliance: In review of the MH charts, one or more of the above elements were missing from the supervisory reviews.	
Corrective Action (policy/procedure, training, environmental changes, etc): Staff training with all Clinical staff.	**Anticipated Date Achieved/Implemented:** **Date** June 18, 2019
Supporting Evidence: Staff training will be held during the clinical staff meeting on June 18. The handout is enclosed as Attachment CC POC-4.	**Person Responsible:** Clinical Director
How Maintained: All new clinical staff will be educated on all facets of the State Contract and its attachments, including training on Treatment Plan Reviews-Annual Supervisory Review.	**Board Notified:** Y ☐ N ☒ n/a ☐

Client Chart POC-5	
Rule #: 67:61:07:10 and	**Rule Statement:** **Transfer or discharge summary.** A transfer or discharge summary for any client within five working days after the client is discharged regardless of the reason for discharge. A transfer

67:62:08:14	or discharge summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan is maintained in the client case record. A process shall be in place to ensure that the transfer or discharge is completed in the MIS. When a client prematurely discontinues services, reasonable attempts shall be made and documented by the agency to re-engage the client into services if appropriate.

Area of Noncompliance: In review of the SUD and MH charts, discharge or transfer summaries were missing one or more the above elements.

Corrective Action (policy/procedure, training, environmental changes, etc): Staff training with mental health clinical staff, SUD clinical staff, and office staff.	**Anticipated Date Achieved/Implemented:** **Date** June 25, 2019
Supporting Evidence: SUD Clinical Staff training was held June 11. Office staff will be trained June 18. MH Clinical Staff training will be held on June 25.	**Person Responsible:** Clinical Director, Clinical Supervisor
How Maintained: All new clinical and casemanagement staff will be educated on all facets of the current State Contract and its attachments, including training on transfer or discharge summaries. New support staff will be trained on entering information into MIS within appropriate time frames if this falls within their duties.	**Board Notified:** Y ☒ N ☐ n/a ☐

Program Director Signature: [signature]	Date: 6-14-19

Send Plan of Correction to:

Accreditation Program
Department of Social Services
Division of Behavioral Health
3900 W. Technology Circle, Suite 1
Sioux Falls, SD 57106
DSSBHAccred@state.sd.us

Attachment A POG-1

Dakota Counseling Institute, Inc.
Incident or Accident Reporting Procedures

1. Secure the safety of the client and act promptly in administering first aid or emergency care if needed.

2. If a referral is necessary of a client to a local hospital or physician, promptly make appropriate transportation arrangements.

3. Notify the Executive Director or Clinical Director promptly of any incident or accident.

4. The primary therapist, case manager, nurse, or counselor of the injured client, or the Executive Director or Clinical Director will follow-up with the client, medical provider, family, etc. as soon as appropriate and/or necessary.

5. Complete dictation of the incident will be filed in the client's chart, including follow-up care.

6. An incident or accident report will be completed as soon as possible and given to the Executive Director to be filed in the report log.

7. If this is a sentinel event which resulted in death not primarily related to the natural course of the client's illness or underlying condition, permanent harm, or severe temporary harm, and intervention required to sustain life, the Division of Behavioral Health must be notified within 24 hours.

Updated May 2019

Dakota Counseling Institute, Inc.
Incident or Accident Reporting Procedures

CLIENT NAME _____

Date of incident/accident_____ Time _____a.m./p.m.
When was incident reported? Time _____a.m./p.m.
To whom was the incident/accident first reported? _____

Exactly what was done prior to the incident/accident?

_____
_____
_____
_____
_____
_____
_____
_____

Description of how incident/accident occurred:

_____
_____
_____
_____
_____

Nature of incident/accident:

_____
_____
_____

Severity of incident/accident

1) No apparent injury _____
2) Minor _____(injury is temporary and does not cause further complication)
3) Major _____(injury is serious causing considerable discomfort)
4) Non-applicable _____

Name witnesses to injury:

_____
_____
_____

Was first aid or medical treatment received: Yes No If yes, describe:

_____
_____
_____
_____
_____

Was referral made to physician? _____
Name of physician seen? _____
Was referral made to a hospital? _____
Hospitalized _____ Treated as Outpatient _____

Describe treatment in detail:

_____
_____
_____
_____
_____

Follow up Treatment:

_____
_____
_____
_____
_____

Division of Behavioral Health Notified: (if appropriate)
Yes_____ NA
DBH Staff Contacted & Date

_____ _____
Signature/Title of person preparing report Date

Dakota Counseling Institute
Sentinel Event Procedures

The definition of a sentinel event is an incident that includes but is not limited to: death not primarily related to the natural course of the client's illness or underlying condition, permanent harm, or sever temporary harm, and intervention required to sustain life.

If a sentinel event occurs, the Executive Director will notify the Division of Behavioral Health within 24 hours.

If there is a fire with structural damage or where injury or death occurs, any partial or complete evacuation due to natural disaster, or any loss of utilities or critical equipment necessary for operation for more than 24 hours, the Executive Director will notify the Division as soon as possible.

Within 72 hours of the event a follow-up written report will be submitted to the Division including:

1. Written description of the event;
2. Client's name and date of birth; and
3. Immediate actions taken by the agency.

Updated May 2019

Attachment A RFQ 2

Dakota Counseling Institute, Inc.
Tuberculin Testing Procedures

Upon hire with follow up in four weeks, employees or volunteers of Stepping Stones Rehabilitation Services will report to the agency nurse for a Tuberculin (TB) skin test. Chamberlain staff will report, and be reimbursed for any fee, to the County Health Nurse.

If the test proves negative, appropriate documentation will be made. Only staff needing this test annually (example for hospital privileges) will be required to report to the nurse on their birthday month for follow up.

If the employee has a positive reaction, they will be required to be seen be a medical physician and have a chest X-Ray. Documentation of the negative x-ray will be given to the executive director. No more than annually this staff will be assessed by a physician for the following symptoms:

1. Productive cough for a two week duration:
2. Unexplained night sweats:
3. Unexplained fevers; or
4. Unexplained weight loss.

If their examination and chest x-ray show that they have an active case of TB, they will follow the recommendations of their medical physician and placed on medical leave until they are cleared to come back to work. Reporting will be made to the South Dakota Department of Health.

Updated May 2019

Attachment A POC-3;

Stepping Stones Rehabilitative Services
Medication Policy

Policy: Control of prescription, non-prescription, and over-the counter vitamins and minerals while the client is a resident of the Stepping Stones Rehabilitation Services (SSRS) Halfway House.

Purpose: The purpose of this policy is to provide the client with assistance in "self-medication" of prescribed and/or over-the-counter medications or vitamins/minerals. All medications, prescribed, not prescribed, or over-the-counter, will be kept in a secure cabinet within the Residential Office to ensure the safety and security of the substance.

I. Stepping Stones Rehabilitation Services resident responsibilities: It is the responsibility of the client to immediately surrender all prescription medications, over-the-counter medications including vitamins and minerals to the Residential Staff as soon as the client enters the facility. This is to ensure the safety and security of each client's medications and to ensure appropriate control of all medicine/health-related substances.

A. Each client who has prescription medication(s) will have a designated area in the medicine cabinet, assigned to them. The staff on duty will ensure the appropriate placement of the medication(s). Residential Staff will be responsible for counting in all medications and documenting orders on the medication administration sheet.

B. Each client is responsible to provide a written order or prescription for any physician prescribed or over-the counter medication brought to the facility. The following information is MANDATORY on prescribed medications:
   - Patient's name on the medication bottle.
   - Correct name and dosage of the medication (i.e. Zantac, 150 mg).
   - The instructions for appropriate times and dosages for administration of the medication (i.e. 1 tablet PO BID until gone).
   - The name of the prescribing Physician (with telephone number if possible).
   - The name and phone number of the filling Pharmacy.
   - The quantity of the medication issued.
   - The number of refills available.
   - The expiration date of the medication.

1. SSRS will keep a "house stock" of appropriate medications for use in emergency situations. This medication will be prescribed by the Medical Director and will be issued under strict control as ordered by the "on-call" physician. Stock supply will be checked for outdates at least once per month. Documentation will be completed no later than twenty-four hours after the emergency situation of what medications were utilized and the outcome or status of the client. The Medical Director will sign off on this documentation.

2. Stepping Stones will also keep a "house stock" of non-prescription strength Ibuprofen, Aspirin, Acetaminophen, and antacid type relief tablets. This medicine will be administered at the discretion of the on-duty Residential Staff under the direction of the Medical Director.

C. The client will be permitted to have over-the-counter medications, vitamins and minerals as appropriate, but all of these substances will be kept secured in the Residential office until the client desires to take said substances. The client will not receive any more dosage than recommended on the container packaging or as directed by a physician.

Note: Only unopened, sealed containers of over-the-counter items may be brought in to the facility. This will prevent accidental/deliberate ingestion of any substance that may have been substituted in the over-the-counter container/packaging.

Note: ALL medications, vitamins and minerals will be taken in the direct view of staff. At no time will the client leave the presence of the Residential Staff without having swallowed ALL of the issued medication. If the client is leaving for an authorized pass, they will be given the correct amount of medication for the duration of the leave.

The client will then place their initials in the appropriate space on the Client Medication Log in the presence of staff. ALL CLIENTS MUST SIGN FOR THEIR MEDICATIONS.

- **Note:** Any client found non-complying with this policy will be subject to immediate, severe administrative action, including possible discharge and/or a report made to the Mitchell Police Department or appropriate Law Enforcement Agency.

II. Residential Staff Responsibilities: It will be the responsibility of staff to request and obtain any prescription and over-the-counter medications, vitamins, and minerals during the admission process. It will also be the responsibility of staff to question clients about medications and/or vitamins and minerals from time-to-time to ensure that all of the above mentioned substances are secured in the Residential Office and documented.

A. It is the responsibility of the Residential Staff to provide prescribed medications at the request of the client with the proper guidelines as outlined in B.

1. In the event that the client feels a medication dosage needs to be changed, they should contact the prescribing physician to have the medication changed or an order faxed.
2. If the client is unable to contact their physician, then staff will contact the Medical Director. If unable to contact either physician, and can not wait, staff can contact Avera Queen of Peace Hospital at 605-995-2000 and request to speak with a Emergency Room physician. No medication can be changed without a written order from a physician.

B. Secured control of all prescription medications in the Residential Office is mandatory. At NO time is a client authorized to store prescriptions, over-the-counter medications, vitamins, and/or minerals anywhere other than the Residential office. (The only exceptions are those medications that must be in the patient's possession such as inhalers, nitroglycerin tablets, etc.)

1. It is the responsibility of the Residential Staff to unlock the medicine cabinet and obtain the appropriate medicine for the client requesting the medicine. All prescription medications will be kept in a 24-compartment storage cabinet (hereafter referred to as the "med cabinet") and will be locked at all times.

2. Residential Staff will keep all controlled meds in the lock box in the med cabinet. This box will be locket at all times.

3. The Residential Staff will select the appropriate container from the client's medication compartment within the med cabinet and will remove that container from the med cabinet. Staff will then read the orders stated on the

container to obtain the proper dosage as stated on the label and observe the client in taking the proper dosage from the container. Staff will monitor the client as they self-administer their own medication. Staff will then return the container to the correct compartment in the med cabinet and will then immediately lock the cabinet.

4. Residential Staff will then complete the required written information found on the Client Medication Log. The client will then sign their initials in the space marked.

5. Staff will complete a separate log book to record the receipt and disposition of all Schedule II, III, IV drugs.

A. It is the responsibility of the Residential Staff to immediately report any violations of this policy by a client to the Residential Supervisor and/or the Clinical Supervisor in writing. Failure to follow the rules of this policy will result in administrative action which could lead to dismissal from employment.

III. Executive Director Responsibilities: The Executive Director will be responsible for appointing a Residential Supervisor that will administer the Medicine Control Policy at SSRS. The selected individual must produce current certification of an Emergency Medical Technician. Also, the selected supervisor must agree to keep the Clinical Supervisor informed of any violations of this policy, in writing, either by a client or by staff.

Attachment CC POC-1

Client Last Name, First Name Date (of Intake)
ST: (start time) ET: (End time)
# of min. or units, Service Type, Service Location

Identifying Information: (Name, DOB, primary race or ethnicity, gender – including gender identity if different from biological gender, marital status, current address and phone number, members of household)

Presenting Problems: (Who referred client; include all problem areas identified by client and any problem areas identified by others/state by whom)

Individual and Family Strengths: (Strengths of the client and the client's family if appropriate, as well as previous periods of success and the strengths that contributed to that success; identify potential resources within the family if applicable)

Individual and Family Needs: (include needs from all life domain areas)

Readiness for Change: (identify readiness to change in any of the problem areas/needs identified above, including motivation and supports for making such changes)

Treatment History: (include previous mental health and substance abuse treatment; psychiatric hospitalizations; psychotropic and other medications currently prescribed; physical illnesses, past and present; medical hospitalizations; history of head trauma, seizures, high fevers; childhood illnesses; accidents)

Family and Social History: (Family history and background; history and dynamics of important current and past relationships; should cover events and a description of life in early and later childhood and adolescence; should cover major life events)

Social Needs: (State "none identified" to indicate that you asked about this)

Substance Use/Disorder History/Needs: (Current and past substance use including misuse of prescription medications, nicotine, caffeine; previous treatment for SUD and gambling; include periods of success and what contributed to this success)

Co-occurring History/Needs: (state "none identified" to indicate you asked about it; indicate co-occurring for medical, substance use or gambling disorder, developmental disability)

Educational History/Needs: (State "none identified" to indicate you asked about this)

Legal Issues: (State "none identified" to indicate you asked about this)

Living Environment or Housing: (If homeless, indicate for how long; if "doubled up" describe situation and for how long)

Vocational/Financial History/Needs: (State "none identified" to indicate you asked about this)

Trauma History/Needs: (include any childhood sexual/physical/neglect abuse; include any other trauma i.e. accidents, witness/perpetrator of violence, etc.)

Domestic Violence History/Needs: (State "none identified" to indicate you asked about this)

Safety Needs/Risks and Plan: (in regards to physical acting out, health conditions, acute intoxication, and suicidal/homicidal ideations and/or plans, danger to self/others)

Behavioral Observations/Mental Status:

Diagnostic Impressions (include any co-occurring diagnoses as "by history" or " rule out")

SED/SMI Determination:

Recommendations:

Initial Plan:

Signature of Clinician

Signature of QMHP Supervisor if Needed

Identifying Information

Presenting Problems

Individual and Family Strengths:

Individual and Family Needs:

Readiness for Change:

Treatment History

Family and Social History:

Social Needs

Substance Use/Disorder History/Needs:

Co-occurring History/Needs

Educational History/Needs:

Legal Issues:

Living Environment or Housing:

Vocational/Financial History/Needs:

Trauma History/Needs

Domestic Violence History/Needs:

Safety Needs/Risks and Plan:

Behavioral Observations/Mental Status:

Diagnostic Impressions

SED/SMI Determination:

Recommendations:

Initial Plan:

Attachment CC: Pg-2

Dakota Counseling-Treatment Plan

Client:	CID#
Date of Intake:	Clinician:
Diagnoses (list all):	
(Circle) SED SMI Not SED/SMI	
Needs: Strengths:	
1. Goal: Measurable Objective: Stage of Change:	Target Date:
2. Goal Measurable Objective: Stage of Change:	Target Date:
3. Goal: Measurable Objective: Stage of Change:	Target Date:
Other services receiving (circle all that apply): Home-Base Pathway Stepping Stones	Psychiatry OP Therapy Rosewood
Co-Occurring (circle): None Drug/Alcohol	Intellectual Disability

Client Signature and Date: _____

Parent/Guardian Signature and Date: _____

Treatment Team Member Signature and Date: _____

Clinician Signature and Date: _____

Supervisor Signature and Date (if needed): _____

Attachment CC POC-3

Dakota Counseling-Treatment Plan Review

Client:	CID#
Date of Review:	Clinician:
Diagnoses (list all):	
Goal #1-Progress: Goal is (circle): completed partially completed discontinued If partially completed, changes:	
Goal #2-Progress: Goal is (circle): completed partially completed discontinued If partially completed, changes:	
Goal #3-Progress: Goal is (circle): completed partially completed discontinued If partially completed, changes	
Justification for Continued Services:	
Additional Goal: Measurable Objective: Stage of Change:	Target Date:
Client Signature and Date: _____ Parent/Guardian Signature and Date: _____ Treatment Team Member Signature and Date: _____ Clinician Signature and Date: _____ Supervisor Signature and Date (if needed): _____	

Attachment CC POC-3

Dakota Counseling-Annual Supervisory Review

Client:			CID#	
Date of Review:			Clinician:	
Current Diagnoses:				
Goal #1-Progress:				
Goal is (circle):	completed	partially completed		discontinued
Goal #2-Prgoress:				
Goal is (circle):	completed	partially completed		discontinued
Goal #3-Progress:				
Goal is (circle):	completed	partially completed		discontinued
Other Services Receiving (Circle all that apply):			Psychiatry	OP Therapy
Home-Base Pathway		Stepping Stones	Rosewood	
Additional Goal-Progress:				
Justification for Continued Need for Mental Helath Services:				
Additional Services Needed:				
Clinician Signature and Date: _____				
Supervisory Signarture and Date: _____				